U.S. Department of Veterans Affairs

The Continuum of Care for PTSD

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POSTTRAUMATIC STRESS DISORDER

ACKNOWLEDGEMENTS

- OMHSP Continuum of Care Workgroup (75+)
- Dr. Tracey Smith, Dr. Jennifer Burden, Dr. Elissa McCarthy, Dr. Cindy Yamokoski, Dr. Pearl McGee-Vincent
- NCPTSD Consultation and Mentor Staff

OBJECTIVES

- Continuum of Care Background and Principles
- PTSD Specialty Care Continuum of Care
- Emerging Trends

CONTINUUM OF CARE BACKGROUND & PRINCIPLES

- Stepped Care Model (Bower & Gilbody, 2005; Ahmedani & Vannoy, 2014; Richards, 2014)
  - Mange limited health care resources including demand for specialty mental health services
  - Improve reach and availability of services
  - "Step up" and "Step down" processes
- Key Elements
  - Least restrictive care available
  - Self-correcting (i.e., movement to different steps)
  - Treatments of differing intensity

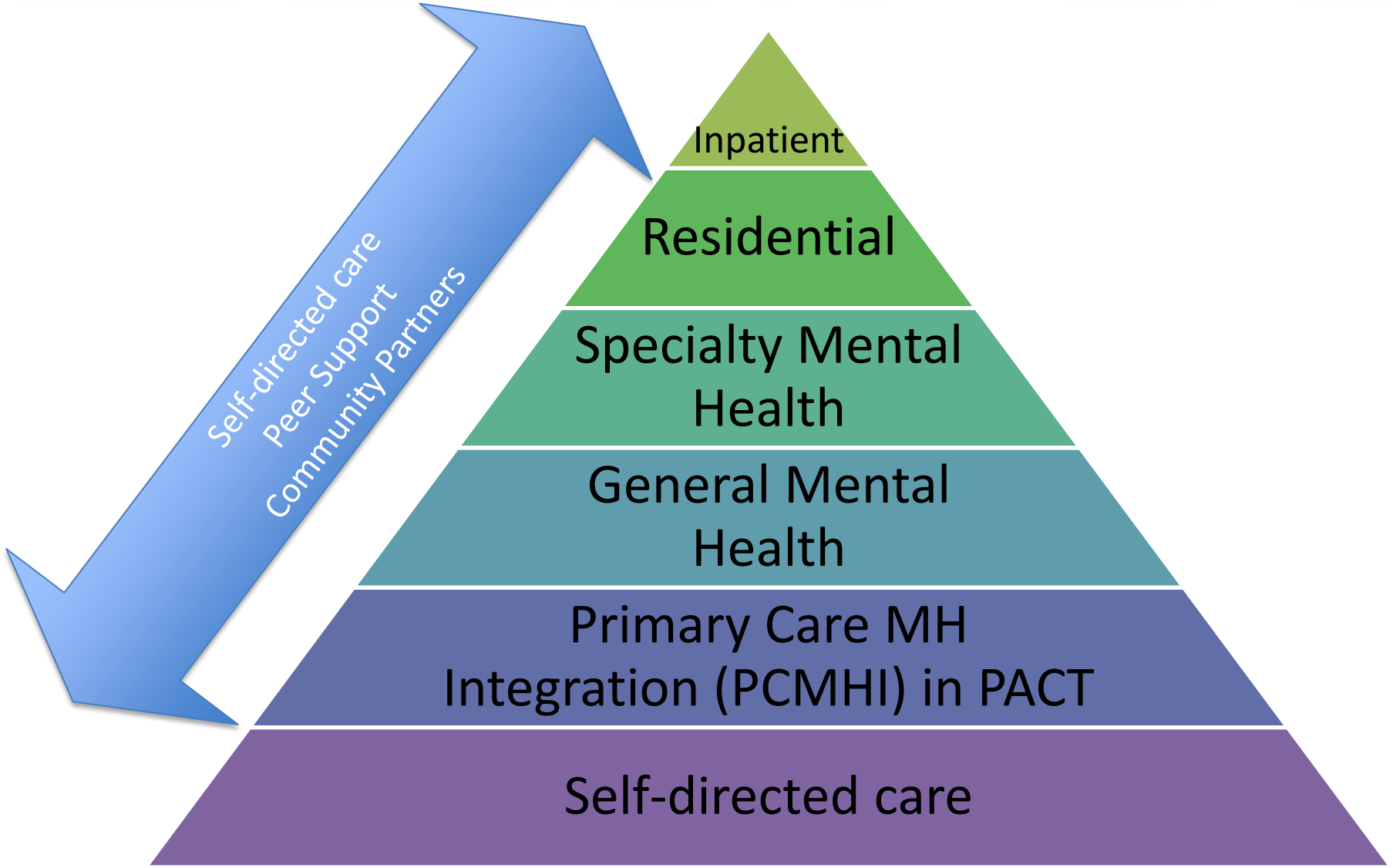
STEPPED CARE MODELS

- Assumptions of Stepped Care
  - Equivalence
    - Minimal interventions equivalent benefit for a proportion of patients
  - Efficiency
    - Utilizing lower levels of care allows for efficient use of other higher healthcare resources
  - Acceptability
    - To both patients and providers

IMPLEMENTATION

- United Kingdom: Improving Access to Psychological Therapies (IAPT)
  - Implementing National Institute for Health and Clinical Excellent (NICE) guidelines within health care system (Clark, 2011)
  - Key Principles: Access, Stepped Care/Guideline concordant, employment, weekly outcome informed discussions
  - Recovery rate 51% and 66.3% show reliable improvement (Clark, 2018)
- Veterans Health Administration Model of Mental Health (Report from the Office of Mental Health & Suicide Prevention)
  - Based on interrelated evidence-informed principles and incorporates existing mental health initiatives

CONTINUUM OF CARE



CONTINUUM OF CARE BACKGROUND & PRINCIPLES

- Least Restrictive Care
- **Measurement-Based Care**
- **Shared Decision Making**
- Recovery-Oriented Mental Health Care
- **Suicide Prevention**
- Medical Necessity
- Team-Based Care
- Practicing at the Top of One's License
- **Flexible Service Delivery Methods**
- Reduction of Redundancy/De-implementation
- VA partners and Non-VA Community Resources

PTSD CONTINUUM OF CARE

- Provision of a PTSD continuum of care implies matching the unique needs of a Veteran with the level of care required at the time, as well as ongoing evaluation of whether the Veteran should receive a greater or lesser level of care.

- All VHA points of service must provide EBP services for the treatment of PTSD, specifically CPT or PE, in person or via Telemental health by trained clinicians.

The Uniform Mental Health Services in VA Medical Centers and Clinics (VHA Handbook 1160.01), Programs for Veterans with PTSD (VHA Directive 1160.03) , Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) (VHA Handbook 1162.02), 2017 Revised VA/DoD Clinical Practice Guideline for Management of PTSD

PTSD CONTINUUM OF CARE

Self-Directed Care	Peer Support	Primary Care MH Integration	General Mental Health/BHIP	PTSD Specialty Outpatient	Residential
•-PTSD Treatment Decision Aid •-About Face •-Whiteboard •-PTSD Coach & other mobile apps •-Beating the Blues internet intervention	➢-Outreach ➢-Mentoring -Goal setting -Support groups -After-care groups	-Brief assessment and screening -Motivational enhancement -PTSD education -Brief protocols for PTSD -Skills building -Referral management	-General Skills -Maintenance of goals after intensive tx -Management of comorbid diagnosis -EPBs for PTSD (availability permitting) -Skills & education groups -Medication	-EBPS for PTSD -Time-limited skills-based interventions for severe sxs -Medication	-Structured environment of care to deliver EBPs for PTSD for: Risk of relapse Attempted or difficulty w/ lower level of care Coping skills required to complete EBP -Medication -Case Management

SELF DIRECTED CARE

- Self-directed care would include participation in any services, interventions, or activities that are primarily driven by patient preference (i.e., time, locations, duration, or level of participation)
- Include but not limited to:
  - Educational materials, videos, mobile apps, websites

LEVELS OF SUPPORT FOR VETERANS' USE OF MOBILE MENTAL HEALTH APPS

Self-Directed Care → **Specialty Mental Health**

Providing Information

Give informational handout, e.g.:

- Flyer about self-care apps
- Flyer about specific app
- Instructions on how to download

Examples of when to provide info:

- One-time visit/infrequent visits (primary care, inpatient, rural settings)
- Subclinical issues/psychotherapy with a provider not indicated
- Before/after an episode of care

Clinical or non-clinical staff can provide information about apps for self-care

Supplement to Treatment

With Veteran's buy-in and access to needed equipment, provider introduces tool(s) that:

- Facilitate treatment (e.g., skills practice, psychoeducation, self-monitoring) for:
  - primary focus of treatment
  - supplemental issues (e.g., anger management)

Use all features of app or select specific tools or features

Care provided is mostly the same as without app

Provider works within scope of practice and knowledge (e.g., is trained in CBT skills in apps)

Provider integrates app in ways that fit with the treatment being provided (e.g., assigning homework with app)

Treatment Companion

For Veterans participating in an evidence-based treatment (e.g., CBT-I, PE, CPT, STAIR, ACT):

- The app is presented as an option (for homework completion, skills practice, self-assessment, etc.)
- Alternatives (e.g., paper worksheets, tape recorder) also presented

EBT is delivered per protocol

Following an episode of care, apps may be recommended for ongoing self-management and self-monitoring of symptoms

- Domiciliary PTSD (DOM PTSD)
  - Residential care to Veterans with PTSD including Military Sexual Trauma in 24/7 structured and supportive environment
  - Strong emphasis on provision of EBPs with inclusion of additional psychosocial and medical services addressing co-occurring needs
  - Need: Severity of illness, high-relapse potential, exacerbation of co-occurring disorders, and absence of safe, supportive recovery environment

PTSD RESIDENTIAL ADMISSION CRITERIA

Veteran must:

- Be assessed as not meeting criteria for *acute psychiatric or medical admission.*
- Have tried a less restrictive treatment alternative, or one was unavailable.
- Be assessed as not a significant risk of harm to self and others.
- Be lacking a stable lifestyle or living arrangement that is conducive to recovery.
- Be capable of self-preservation and basic self-care.
- Have identified treatment and rehabilitation needs, which can be met by the program.

Veterans cannot be denied admission based <u>solely</u> on:

- Length of current abstinence from alcohol or non-prescribed controlled substances
- Number of previous treatment episodes
- Time interval since last residential admission
- Use of prescribed control substances
- Legal history

*Screening process must consider each of these and determine if program can meet the Veterans needs while maintaining safety, security and integrity.

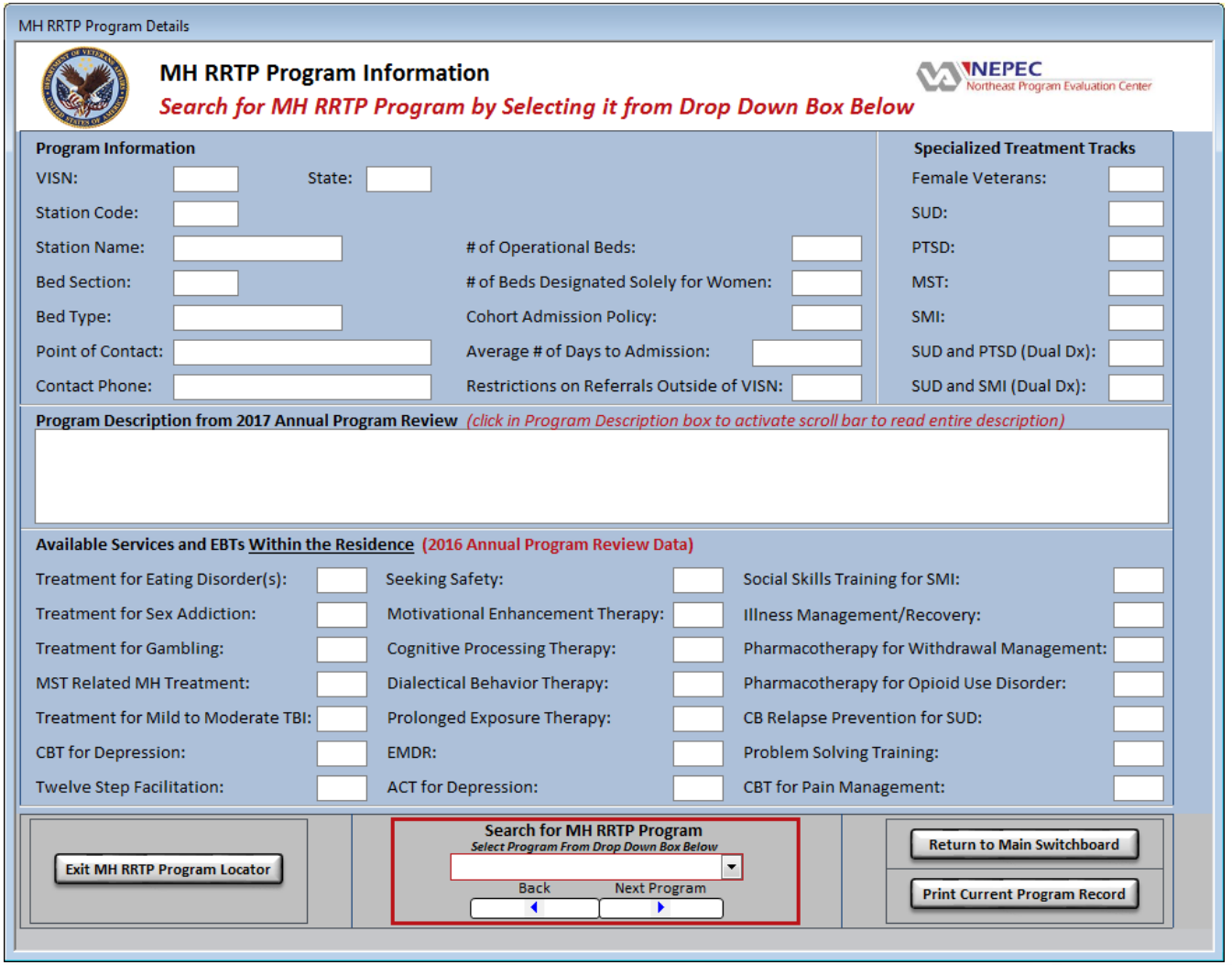
RESIDENTIAL STEPPED CARE CONSIDERATIONS

- Safety prior to Residential Treatment
  - Collaboration and contact prior to admission – required weekly
  - Help patients follow through with preadmission plans re: safety behaviors

- Safety following discharge from Residential Treatment
  - The safety plan has been updated. Is everyone on the same page? Are there new resources to add?
  - Collaborative mobilization of Veteran's social support system
  - Minimum of 2 encounters following discharge (4 for some Veterans) with expectation for first encounter within 7 days

REFERRING TO RESIDENTIAL TREATMENT

- MHRRTP Program Locator



PTSD Consultation Program

- Dr. Elissa McCarthy is a consultant specializing in questions related to assessment and treatment, including: Cognitive Processing Therapy, Prolonged Exposure, Cognitive Behavioral Therapy for Insomnia, and **residential treatment programs**.
- She is a clinical psychologist with experience in training other clinicians in evidence-based therapy.
- She has experience working in a **VA residential treatment program for PTSD** and continues to deliver evidence-based psychotherapies through the VA Connecticut Healthcare System.

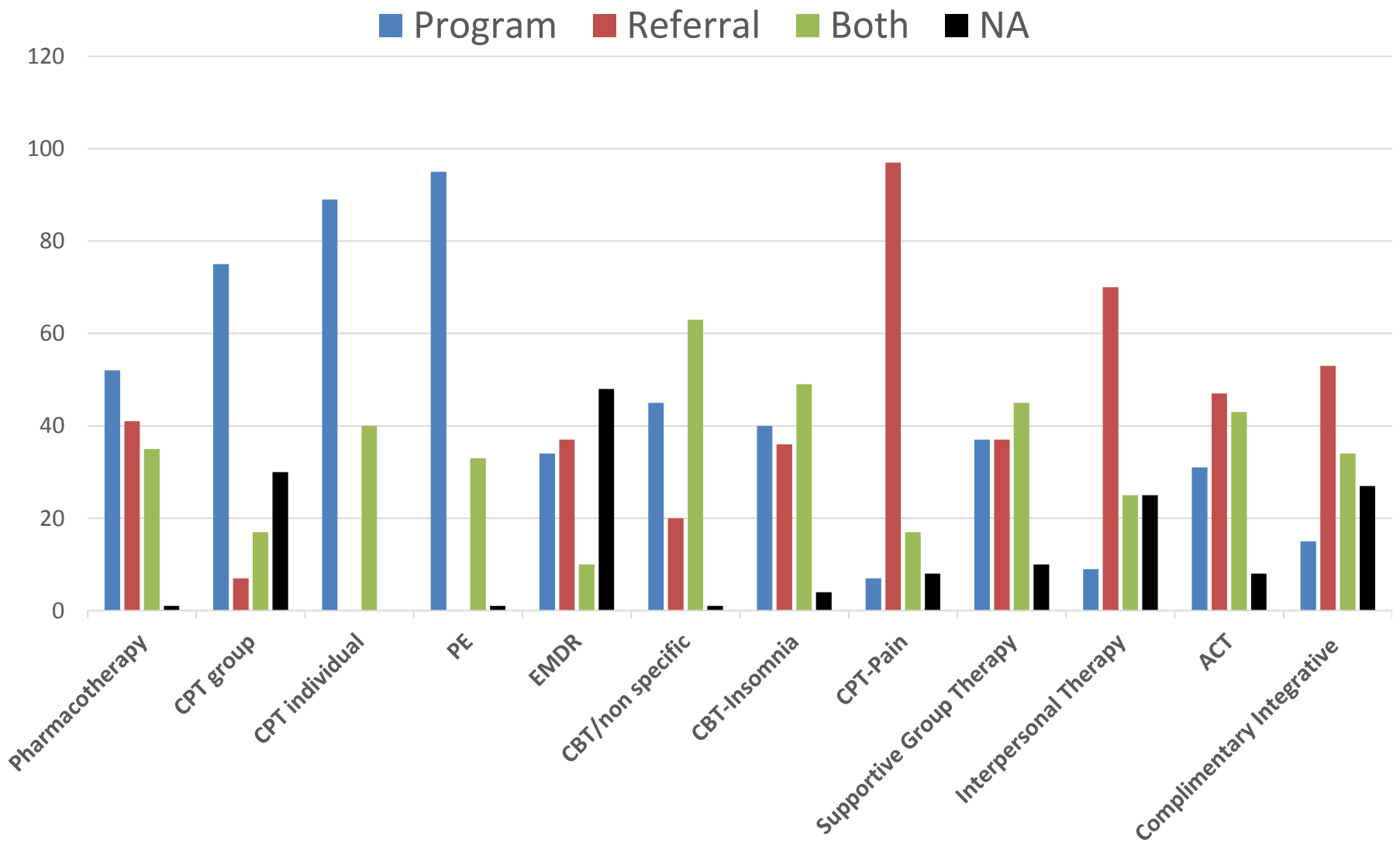
Elissa McCarthy, PhD

Consultant

PTSD OUTPATIENT SPECIALTY CARE

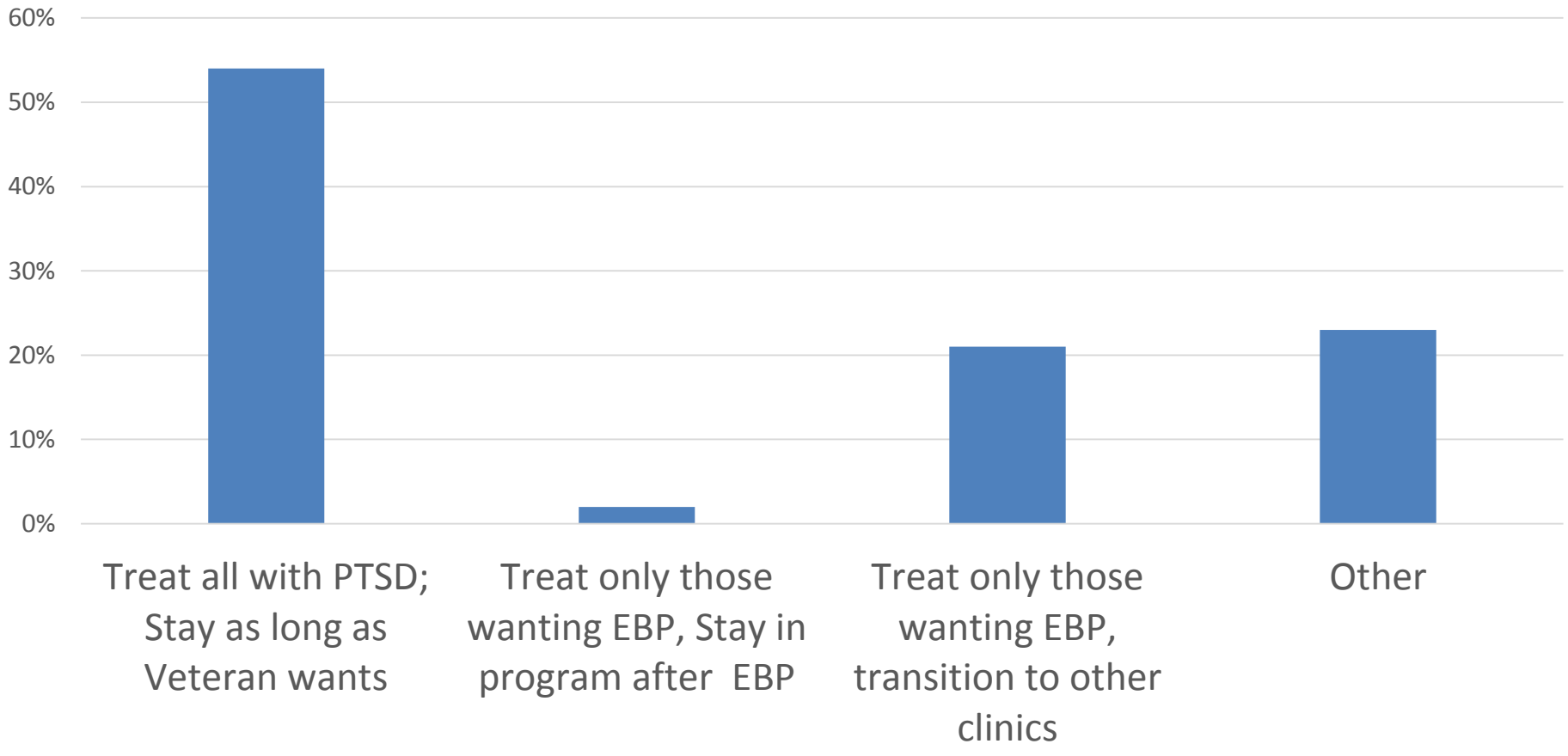
- PTSD Clinical Team (PCT) and PTSD Specialists
  - Provide resource of expertise for entire facility
  - Knowledgeable of assessment and diagnosis of PTSD and military culture
  - Scope and flow of services is often determined by local continuum of care resources

PTSD OUTPATIENT SPECIALTY CARE



PTSD OUTPATIENT SPECIALTY CARE

Patient Flow in PTSD Clinical Teams FY'17



N=129; Source: NEPEC FY' 17 Annual Review for Specialized PTSD Programs

PTSD SPECIALTY OUTPATIENT SCOPE OF SERVICES

- Context Matters... (Sayer et al., 2017)
  - Promoting Effective, Routine, and Sustained Implementation of Stress Treatments (PERSIST)
  - Identify organizational and team factors that promote high levels of reach of EBPs for PTSD to patients seen on outpatient PTSD teams
  - 9 sites, 10 PTSD teams
    - High (38.6%-58.9%)
    - Medium (28.8%-31.7%)
    - Low (14.0-17.7%)

Domains	High Reach Teams	Low Reach Teams
Clinic Mission or Purpose	Time-limited specialty clinics. Primary purpose was delivering CPT and PE in weekly sessions.	General mental health clinics for patients with PTSD. Provided all types of mental health care for as long as patients needed & wanted it.
Team Engagement in EBP Delivery	Team leaders were experts in and champions of EBPs. They built staff commitment to the clinic's EBP mission.	Team leaders saw EBPs as only one of many valuable treatment options. There was variability in staff commitment to EBPs.
Clinic Operations/ Procedures	High reach teams developed procedures to facilitate EBP delivery.	Low reach teams grafted EBPs on existing clinic procedures.
Staff Perceptions of CPT and PE	CPT and PE seen as helping most patients, more effective than other treatments, and benefitting clinic.	CPT and PE seen as beneficial for some but not most patients. Perceived benefit for clinic was variable.
Broader Practice Environment	Support from facility and MH leadership enabled focus on EBPs, including ability to refer patients out of clinic.	Facility did not support specialized EBP mission; team expected to provide a broad range of services as long as patients need and want them.

STEPPING THROUGH THE CONTINUUM

We are in this together!

- Care coordination agreements/MOU
  - Who is most appropriate?
  - Scope of services available
  - Expectations regarding treatment episodes and discharge
- Multiple data sources for shared-decision making and transition planning
  - MBC, Patient/Provider, program-level resources
- Leadership Support for CoC

EMERGING TRENDS: EXPANDING THE CONTINUUM

- Brief Prolonged Exposure for PTSD to Primary Care (Cigrang et al. 2017)
  - PE-PC: Treatment delivered in 4 thirty-minute sessions
  - VA PCMHI Training Plan Underway
  - 1 in 5 patients with PTSD will only see PCP for treatment –refuse MH referral

EMERGING TRENDS: EXPANDING THE CONTINUUM

- Massed EBPs for PTSD: Intensive Treatment Care Models (Foa et al., 2018; Hendriks et al., 2017; Ehlers et al., 2014)
  - PE and Cognitive Therapy
  - Condensed time period
    - Intensive treatment provided in less than 2 weeks
  - Similar to greater sessions/hour than standard
    - Massed PE=10 sessions; iPE=12 sessions; CT=14 sessions
  - Completion rates…
    - 86%; 95%; 97%

EMERGING TRENDS: EXPANDING THE CONTINUUM

- Wounded Warrior Project: Warrior Care Network (WCN) https://www.woundedwarriorproject.org/programs/warrior-care-network
  - 4 Academic Medical Centers
    - Emory Healthcare- *Veterans Program*
    - Rush University Medical Center-*Road Home*
    - Massachusetts General Hospital-*Home Base*
    - University of California (UCLA) *Operation Mend*
  - *2 to 3 week programs: PE and CPT*
  - *Includes: family support, wellness, case management*
  - *VA MOU to ensure collaboration and post treatment coordination;*
    - *AMC Case Manager ⟷ VA Liaison ⟷ VA Case Manager*
  - *Completion rate: 93.5% (n=572)*
  - *Effectiveness: Cohen's d=1.07 (n=428)*

EMERGING TRENDS: EXPANDING THE CONTINUUM

- Cleveland VAMC Intensive Program
  - Two week program
    - Daily individual PE
    - Check in groups +mindfulness
    - Group in-vivo exposure
    - Yoga twice weekly
  - Four week program
    - 3 times weekly individual CPT or PE
    - Attend groups with 2 week cohort
  - Additional treatment options via substance use program

SUMMARY

- Provision of a PTSD continuum of care implies matching the unique needs of a Veteran with the level of care required at the time, as well as ongoing evaluation of whether the Veteran should receive a greater or lesser level of care.

- Successful implementation of the stepped care model relies on integration of the key principles